BlueCross BlueShield
Federal Employee Program

FEP Medical/Surgical Prior Approval (Pre-service Inquiry)

Patient Name (Last, First, Middle Initial)	Certificate Holder Identification Number		Patient's Date of Birth / /
Certificate Holder Name (Last, First, Middle Initial)	Patient's Sex ☐ M ☐ F	Relationship to Certificate Holder ☐ Self ☐ Spouse ☐ Dependent	Provider NPI#
Address	Provider Telephone Number	Provider Fax Number	
City, State, Zip Code	Diagnosis		
Provider Name (Last, First, Middle Initial)	Diagnosis Code		
Address	Additional Information (Attach medical necessity documentation as necessary.)		
City, State, Zip Code			

Services To Be Approved

Anticipated Date of Service	CPT/HCPC Codes	Description of Service	DME Charge	DME Allowance
/ /				
/ /				
/ /				

I certify the accuracy and completeness of all information reported by me on this form.

Provider Signature ______________________________ Date ______/______/______

☐ **Other** ______________________________

Outcome

☐ Medically Approved: ______________________________

Effective Dates of Approval: From ______/______/_____ to ______/______/______

Other Limitations of the Approval: ______________________________

☐ Denied, Not a Contract Benefit______________________________

☐ Denied ☐ Cosmetic ☐ The efficacy of this procedure has not been established

This decision is for the procedures or services identified above and is subject to the following conditions:

- **Approval is granted on the basis of the terms of the contract that provides benefits for this patient that is in effect on the date of the approval. If, for any reason, the patient's coverage should change before the service is provided, other limitations will apply and you should contact Wellmark for verification of membership.**
- **Payment, for the above service(s), will be limited by the maximum allowable fees in effect for this service on the date the service is performed and limited by any benefit maximum amounts provided in the contract. The member may be responsible for charges in excess of the payment. Financial responsibilities should be discussed before the service is provided.**
- **If the member's contract requires a referral, precertification, preprocedure review or second opinion, these must be obtained prior to admission to the hospital or before the service is provided. Failure to do so may result in a benefit reduction or denial of benefits.**
- **If youneed an extension to the effective dates indicated above, please contact Wellmark.**
- **Additional questions should be directed to Wellmark's Provider or Customer Service.**

Additional Information

The Office of Personnel Management will not grant an appeal of the decision. The standard reconsideration process as outlined in the BCBS Service Benefit Plan Brochure does not cover this provision. If you have further questions concerning the specific coverage, please feel free to contact our FEP Dedicated Service Center at 1-800-532-1537 between the hours of 9:00 a.m. and 5:00 p.m., CT.

Wellmark Signature______________________________ Date ______/______/______

Provider: Please complete this form and submit it to Wellmark at one of the addresses or fax numbers given below.

Wellmark Blue Cross and Blue Shield of Iowa

Prior Approval Unit - Mail Station 5W198
PO Box 9232
Des Moines, Iowa 50306-9232
Fax: 515-376-9016